Prior Authorization Request Form

Minimum Required Information

Client Information	Enter Required Data
Client MID	Complete client Medicaid Identification Number. It is the responsibility of the requestor to verify current client eligibility prior to request
Client Name	Name as it appears on their Medicaid ID card
Client DOB	Clients Date of Birth
Client Phone	Phone number where client/guardian may be reached for verification of request
Client Address	Clients actual physical address (residence)
Client City/State/Zip	City, state, zip code for clients address
Access to Personal Vehicle	Transportation is not authorized if client has access to a personal vehicle. Identify why the client is not driving self or using other free transport resources
Clients Healthy Connections Dr. (if applicable)	If client is enrolled in Healthy Connections, enter name of primary care provider
Special Transport Needs	Enter special needs for this client such as wheel chair, ambulance, etc.
Medical or Clinic Provider Information	
Medical Services To Be Received	Provide only enough information to determine if medical service is a covered service. Example: Counseling IS NOT adequate as many types of counseling are not covered such as marital, vocational etc.
Clinic or Provider Name	Actual name of the clinic, or individual medical provider if a solo practitioner
Clinic or Provider Phone	Phone number where appointment can be verified
Clinic or Provider Address	Clinic Address where client will be transported to
Physician Referrals (if service is outside of local community)	If request is to transport client out of their community to a distant provider, certain steps must be followed to ensure the same service is not available locally: The following documentation is required: **From The Referring Physician:** • Diagnosis • Reason for the referral to a distant provider • Statement that equivalent services are not available locally • Brief history of the clients case **From the Distant Receiving Physician:** • Acknowledgement they have accepted this Idaho Medicaid client • Date and time of appointment • Anticipated medical services to be provided • Estimated length of treatment and follow-up visits based on the referral information received from the referring physician

	• Statement that the medical services to be provided are not available in the clients community or at a closer location • Receiving physician understands he/she must contact the Department directly for services requiring prior authorization or extended medical care. • Provide the Idaho Medicaid Provider Identification number
Transport Information	
Date(s) of Transport	From Date: 1st date of transport To Date: Last date of transport This will be the same date unless request was for a "blanket authorization" to include several dates
Appointment Time	Time of Appointment
Blanket Authorization	Yes ( ) No ( ) Check if this is or is not a blanket request
For A "Blanket" – Circle Days Of The Week	M T W TH F S SUN (Circle Days of Transport That Apply)
Pick-Up Address	Physical address where client will be picked up. May enter "home" if same as client address
Drop Off Address (End of Transport)	May enter home if being returned home
Total One Way Miles Per Trip	Total one way miles client was transported. Be certain this is the one way mileage ONLY.
Services Requested	
Procedure Codes Requested	Enter the transportation procedure code you will be billing to Medicaid. Check Notification of Decision Letter when received to be certain mileage and procedure code are correct PRIOR TO billing.
Units Requested	1 Unit = 1 mile. Enter total ROUND TRIP miles for this request. If this is a blanket request, enter TOTAL MILEAGE for the entire blanket authorization which would include all trips.
Price Per Unit	Enter the "price per unit" which should appear on the Notice of Decision Letter calculated with rate chart.
Notes:	Enter notes that may apply to this request